APPEAL NO. 042744
FILED DECEMBER 20, 2001

This appeal arises pursuant to the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. § 401.001 *et seq*. (1989 Act). A contested case hearing (CCH) was held on October 13, 2004. The hearing officer resolved the disputed issue by deciding that the respondent's (claimant) impairment rating (IR) is 32%. The appellant (carrier) appealed, disputing the IR. The claimant responded, urging affirmance.

DECISION

Reversed and remanded.

It was undisputed that the claimant sustained a compensable injury to his lumbar and cervical spine on _____. The evidence reflects that the claimant underwent a multilevel fusion to the lumbar spine in January of 2003. The parties stipulated that the claimant reached maximum medical improvement (MMI) on May 29, 2003. At issue is the claimant's IR. We note that the medical records additionally indicate that the claimant had a prior L5-S1 anterior interbody fusion in 1994.

Section 408.125(c) provides that the designated doctor's IR report has presumptive weight and that the Texas Workers' Compensation Commission (Commission) shall base its determination of IR on that report unless the great weight of the other medical evidence is to the contrary.

A letter of clarification dated May 3, 2004, was sent to the Commission-appointed designated doctor requesting that he rate the various body parts which were alleged to be included as part of the compensable injury separately because some of the injuries alleged were in dispute. In response, the designated doctor assessed impairment of 20% for the lumbar spine using the Guides to the Evaluation of Permanent Impairment, fourth edition (1st, 2nd, 3rd, or 4th printing, including corrections and changes as issued by the American Medical Association prior to May 16, 2000) (AMA Guides) placing the claimant in Diagnosis-Related Estimate (DRE) Lumbosacral Category IV, "according to [Commission] Advisory 2003-10," and 15% impairment for the cervical spine placing the claimant in Cervicothoracic DRE Category III "for C7 radiculopathy with a positive EMG." Using the combined values chart, the ratings assessed would produce an IR of 32%.

The carrier argues that the designated doctor's assessment of impairment for the cervical spine was incorrect because it is not supported by the evidence. The carrier contends that the medical records show clearly that the claimant did not have radiculopathy. The EMG report dated April 6, 2004, was in evidence and stated under impression of the test that "there is no evidence of a cervical radiculopathy." The impression was that it was an abnormal study and the assessment was cervical radiculitis, possibly affecting the C6-7 nerve roots and bilateral median neuropathy at

the wrist (carpal tunnel syndrome) mild to moderate in severity, right greater than left. We note that the parties agreed at the CCH to withdraw the issue of whether the compensable injury of _____, includes bilateral carpal tunnel syndrome. The EMG report in evidence further states that the radicular component and the neck pain is most likely related to a cervical radiculitis. The hearing officer noted that there is no medical opinion indicating that the designated doctor has "improperly construed the medical reports he relies on in rating a cervical radiculopathy based on EMG." According to DORLAND'S ILLUSTRATED MEDICAL DICTIONARY (27th edition) radiculitis and radiculopathy are defined differently.

The carrier argues that the 20% lumbar IR assessed by the designated doctor is in error because it is based on Commission Advisory 2003-10, signed July 22, 2003. The carrier contends that both Advisory 2003-10 and Advisory 2003-10B, signed February 24, 2004, are contrary to applicable law and the AMA Guides and are invalid. We have previously held that whether the Commission exceeded its authority in issuing the Advisory and whether it is contrary to the 1989 Act and rules are matters for the courts. *See* Texas Workers' Compensation Commission Appeal No. 041429-s, decided August 4, 2004.

The carrier argues that the designated doctor did not apply Advisory 2003-10 correctly because it is clear from the record that the designated doctor did not first consider the flexion and extension x-rays performed prior to the lumbar fusion of the claimant. A medical record in evidence dated September 13, 2002, stated that, "[t]he request for surgery has been denied. The insurance company is suggesting that we do flexion and extension x-rays. We have, and they show the pseudarthrosis that I told them was there with a 5 or 6 degree arc of motion between flexion and extension at L5-S1." A letter of clarification dated February 4, 2004, was sent to the designated doctor which asked him to document the objective clinical findings present on preoperative x-rays; document where the AMA Guides equate a multilevel fusion with multilevel spinal segment structural compromise; and to explain whether his decision to change the impairment assessed for the lumbar spine from 10% to 20% was based on receipt of Advisory 2003-10 and it's interpretation and application of the AMA Guides. The designated doctor responded in a letter dated March 1, 2004, and acknowledged receipt of the February 4, 2004, letter of clarification. However, his response did not acknowledge or comment on the preoperative x-rays but responded that the claimant's lumbar fusion would qualify as DRE Lumbosacral Category IV according to Advisory 2003-10. In a letter dated June 2, 2004, the designated doctor again opined that the impairment for the lumbar spine would be 20% because of his fusion and referenced an EMG performed on April 6, 2004, which revealed cervical radiculitis but did not provide an assessment of impairment for the cervical spine. As previously stated, the designated doctor on July 13, 2004, assessed 20% impairment for the lumbar spine "according to Advisory 2003-10" and 15% impairment for the cervical spine "for C7 radiculopathy with a positive EMG."

Advisory 2003-10 provides the following clarification for rating spinal fusions:

Clarification of Rating for Spinal Fusion(s)

> For spinal fusion, the IR is determined by the preoperative x-ray tests for "motion segment integrity" (page 102, 4th Edition of the Guides to the Evaluation of Permanent Impairment). If preoperative x-rays were not performed, the rating may be determined using the following criteria:
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> a. One level uncomplicated fusion meets the criteria for DRE Category II, Structural Inclusions. This spinal abnormality is equivalent to a healed "less than 25% Compression Fracture of one vertebral body".
>
> b. Multilevel fusion meets the criteria for DRE Category IV, Structural Inclusions, as this multilevel fusion is equivalent to "multilevel spine segment structural compromise" per DRE IV. [Emphasis in original.]

Although he was asked specifically to comment about the preoperative x-rays in a letter of clarification, there is no indication that the designated doctor did so. The hearing officer noted in his Background Information that the motion measured in the claimant's back was post surgical fusion at the L5-S1 level (due to an injury prior to the compensable injury at issue) and that there was no evidence of the amount of motion at this level previous to the initial fusion. The hearing officer further explained that "Advisory 2003-10 applies in this case because there were no pre-surgical x-rays showing loss of motion segment integrity, and there has been a two level fusion done which the designated doctor has properly rated in [DRE Lumbosacral] Category IV."

It appears to be undisputed that the presurgery flexion and extension x-rays were taken prior to the lumbar fusion the claimant underwent for the compensable injury. In Appeal No. 041429-s, *supra*, we pointed out that the Advisory 2003-10 instructs that a rating for multilevel spinal surgery under subsection b is permissible "if preoperative x-rays were not performed." The Advisory does not by its terms provide exceptions for those cases where a fusion has been performed prior to the compensable injury and we decline to recognize such an exception. In Texas Workers' Compensation Commission Appeal No. 042108-s, decided October 20, 2004, we held that Commission Advisories 2003-10 and 2003-10B do not require the assignment of an impairment rating based on DRE Category IV if there is a multilevel spinal fusion, but that the Commission advisories must be considered as part of the certifying doctor's process in determining the appropriate IR. Further, Appeal No. 042108-s, *supra*, held an IR based on DRE Category IV for a multilevel spinal fusion may not be assigned if flexion and extension comparison x-rays were taken, prior to the surgery, that would show whether there was spinal loss of motion segment integrity as described in the AMA Guides at pg. 3/98 and 99. Since the designated doctor assessed impairment for the lumbar spine solely on the basis of Advisory 2003-10, we remand this case back to the designated doctor for comment about the clinical findings present on the preoperative flexion and extension x-

rays. Since preoperative x-rays were performed we cannot agree that it was appropriate for the designated doctor to assess impairment for the lumbar spine in DRE Category IV based solely on Advisory 2003-10, without further explanation. There is no evidence that the designated doctor considered the preoperative x-rays in determining impairment for the lumbar spine. Additionally, we remand this case to the designated doctor for further explanation of his basis for impairment assessed for the cervical spine when the EMG in evidence and referred to in his reports specifically state that there is no evidence of cervical radiculopathy.

We reverse the determination that the claimant's IR is 32% and remand this case back to the hearing officer. On remand, a letter of clarification is to be sent to the designated doctor directing him to consider the preoperative flexion and extension x-rays in determining the impairment for the lumbar spine and to further explain his basis for the assessment of impairment of the cervical spine. If the designated doctor is no longer qualified or refuses to respond to the clarification, a second designated doctor should be appointed. After the designated doctor has responded or impairment is certified from a second designated doctor if necessary, the hearing officer should allow comment by the parties. The hearing officer should then issue a new decision regarding the IR consistent with this decision.

Pending resolution of the remand, a final decision has not been made in this case. However, since reversal and remand necessitate the issuance of a new decision and order by the hearing officer, a party who wishes to appeal from such new decision must file a request for review not later than 15 days after the date on which such new decision is received from the Commission's Division of Hearings, pursuant to Section 410.202 which was amended June 17, 2001, to exclude Saturdays and Sundays and holidays listed in Section 662.003 of the Texas Government Code in the computation of the 15-day appeal and response periods. *See* Texas Workers' Compensation Commission Appeal No. 92642, decided January 20, 1993.

The true corporate name of the insurance carrier is **ASSOCIATION CASUALTY INSURANCE COMPANY** and the name and address of its registered agent for service of process is

HAROLD FISHER, PRESIDENT
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AUSTIN, TEXAS 78731.

_____
Margaret L. Turner
Appeals Judge

CONCUR:

_____
Thomas A. Knapp
Appeals Judge

_____
Robert W. Potts
Appeals Judge